CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Memorandum

TO: HONORABLE MAYOR AND CITY COUNCIL

FROM: Mark Danaj

SUBJECT: **HEALTH INSURANCE EXPENSE REDUCTION STRATEGY**

DATE: 05-17-06

Approved /s/ Date 05/26/06

EXECUTIVE SUMMARY

Health insurance expenses continue to increase at rates that exceed most public employers' revenue growth. This dilemma is occurring nationally due to longer life spans, the increased cost of prescription drugs, emerging technologies and, in California, hospitals' costs associated with mandatory earthquake retrofitting. In the City of San Jose, the rising costs have been exacerbated by the increase in the average age of employees from 43 to 47 over the past five years.

Between the City, the retirement funds, employees and retirees, health insurance premium payments totaled $68 million in 2004-05. Projecting the average annual increase of 16.5% per year since 2001-02, premium payments will approach $150 million by 2009-10. In the 2006-07 Proposed Operating Budget, the City's share of health insurance premiums is estimated to be $47 million, or 5.5% of the $850 million operating budget. It is important for the City to actively manage this significant portion of our operating resources.

While the City has taken some steps to manage its share of premium expenses (i.e., application of market pressure to carriers and cost-sharing), additional opportunities remain for the City to collaborate with plan participants to address the underlying drivers of health insurance expenses.

BACKGROUND

This memorandum is prepared in response to the Mayor's March 2006 Budget Message to report on medical insurance expense reduction initiatives to manage use and demand for services.

The City offers employees and their eligible dependents a choice of four health plans.

- The Kaiser plan is a pre-paid group practice health organization which provides direct services through Kaiser Foundation hospitals, medical offices and physicians only.
- The Blue Shield HMO plan is a health maintenance organization that contracts with medical groups and facilities to provide medical services to its members.

- The Blue Shield PPO (preferred provider organization) plan is a two-tiered preferred/non-preferred provider health care plan in which members may choose from in or out-of-network providers using a broader network of medical providers.
- The Blue Shield POS (point-of-service) plan is a three-tiered point of service health care plan that provides varying levels of coverage and offers participants the greatest freedom of choice—the ability to choose at any time among low-cost HMO providers, specialist PPO providers or out-of-network providers.

Non-Medicare-eligible retirees have the same four health plan options available to active employees. Medicare-eligible retirees are offered a complex selection Medicare-specific products developed by Kaiser, Blue Shield and PacifiCare.

In the aggregate, the total premium expenses for the City, the retirement funds, employees and retirees were $68 million in 2004-05. That amount constitutes a 16.5% increase per year from $43 million in 2001-02. Assuming that same rate of increase throughout, total premium expenses will approach $150 million in 2009-10.

Rising Health Insurance Premiums

	2001-02	2004-05	2009-10[1]
City	$26 Million	$39 Million	$88 Million
Employees	$2 Million	$5 Million	$7 Million
Retirement/Retirees	$15 Million	$24 Million	$51 Million
TOTAL	$43 Million	$68 Million	$146 Million

According to the federal Health Care Financing Authority, cost increases are due primarily to longer life spans, the cost of prescription drugs and emerging technologies. In California, cost increases are even higher due to hospitals' costs associated with mandatory earthquake retrofitting. In the City of San Jose, the rising costs have been exacerbated by the increase in the average age of employees from 43 to 47 over the past five years.

The City's share of health premium expenses has increased from $26 million to $39 million from FY 01-02 to FY 04-05, an annual rate increase of 14.5%.

ANALYSIS

In terms of health insurance expense reduction initiatives, strategies generally can be categorized into one of the following:

- Applying market pressure to insurance carriers
- Sharing costs with plan participants

[1] Extrapolation at 16.5% per year based on actuals between 2001-02 and 2004-05. Assumes no changes in the multiple components that can affect rates either positively or negatively.

- Exploring alternative plan designs
- Managing utilization
- Auditing for efficiency

The City employs these strategies to varying degrees as described below.

Applying Market Pressure To Insurance Carriers—The City already employs effective strategies in this category.

— Since 1994 when the City's own health plan was closed due to cost overruns, Employee Services has conducted a health plan request for proposals (RFP) at least every four years. While the marketplace has prevented multi-year rate guarantees for the past 10 years, the RFPs have been used to identify and secure new plan design features (e.g., prescription drug formularies).

— The current agreements with the City's insurance broker require that each year's rate quote from the insurance carrier be reviewed by an independent actuary/underwriter. This practice gives the City an ability to counter each year's rate quote, as appropriate, based on data and standard underwriting methodologies.

Sharing Costs With Plan Participants—The City's share of the health care premiums is based upon the cost-sharing formulas negotiated with the City's bargaining units. The monthly premium cost-sharing formula for most employees states that the City pays 90% of the lowest-priced plan (Kaiser) except that an employee's 10% portion cannot exceed $50 per month in 2006. (If the 10% portion exceeds $50 per month, the City pays the excess.) The City's contribution to the more expensive Blue Shield plans is the same dollar amount it pays towards Kaiser, and the participant pays the balance. Additional changes to the cost-sharing formulas have been negotiated with several bargaining units for 2007 and 2008.

Exploring Alternative Plan Designs—Through plan design, employees share costs in the form of copayments, deductibles and out-of-pocket maximums, where the annual out-of-pocket costs for participants depends on an individual's own utilization. These copayments, deductibles and out-of-pocket maximums vary between the plans offered by the City, and are generally characterized as relatively low. Low copayments minimize out-of-pocket expenses for utilizers. It should be noted that higher copayments can prevent over-utilization.

The City's copayments could be higher resulting in lower monthly premiums without severe adverse impacts on most of the plan participants and mitigate the City's health care expenditures.

Managing Utilization—This category of strategy has a potential to minimize the City's health insurance premiums. Utilization management programs seek to minimize health insurance costs by promoting continued healthy lifestyles among healthy individuals and by ensuring that individuals with treatable conditions are aware of effects of certain lifestyle habits. This could result in a measurable impact to the City because our plans are large enough to be "experience-rated," meaning that our own utilization is the primary determinant of the following year's premium rates. In the Blue Shield plans, about 85% of the each year's quoted rates are based on our own experience.

Between employees, retirees and dependents, the City's health plans cover 13,000 individuals. The Centers for Disease Control and Prevention state that 50% of our health status is influenced by health behaviors such as smoking, diet, exercise, alcohol, etc. Further, the Institute For The Future states that 15% of plan participants typically drive 88% of plan costs. These figures suggest that the City has opportunities both to manage the care of the 15% of the plan participants with the highest utilization and to promote healthy lifestyles by the remaining 85% of the population.
Examples of utilization management programs include the following:

— Disease management programs—These are programs in which individuals known to have certain diseases (e.g., diabetes, cardio vascular disease, depression, hypertension, asthma, etc.) are offered intervention and specialized care programs to keep their chronic conditions and related costs under control. These disease management programs target the top 15% of the health plans' utilizers.

  In addition, some disease management programs may also include outreach to individuals who have known risk factors (e.g., obesity, lack of exercise, poor diet) . Education, counseling and screenings are effective strategies for this population to help develop and maintain appropriate lifestyle habits that will avoid having their risk factors escalate to a disease state.

— Wellness programs and incentives—These programs may or may not overlap the disease management programs, depending on plan design. They target the broader population and reinforce healthy lifestyle habits through education, communication, screenings and incentive programs. In the City, they would target the day-to-day activities of our 13,000 plan participants and focus on the prevention of more serious and expensive health conditions.

Currently, the City does not invest resources in its own utilization management programs. While Kaiser and Blue Shield have their own disease management programs triggered within their own data systems (i.e., when a cost is incurred related to certain diagnoses), their programs are not employer-specific, and the City cannot report on their programs' effectiveness or success with City plan participants.

Auditing For Efficiency—This category of expense reduction strategies is one of due diligence. These strategies focus on the service delivery and payment systems, and ensure that they operate efficiently and accurately in ways that minimize unnecessary expenses and higher premiums. These would be responsible investments for any payer of insurance premiums.

Examples include the following:

— Eligibility audits to ensure that services and claims are not authorized for ineligible participants such as former employees, over-age dependents, former spouses, etc.
— Claims management audits to ensure that particularly expensive treatment programs are neither under- or over-utilized.

— Claims processing audits to ensure that all payments are made in accordance with negotiated contracts and fee schedules, especially those that offer discounts or fixed pricing.

Additional Efforts—In addition to the above strategies, the City is participating in two coalitions of public agencies that have been formed to address this same issue of rising health costs.

— The Santa Clara County Health Benefits Coalition has been formed under the leadership of Jim Beall, County Supervisor, and Hal Plotkin, Trustee, Foothill-De Anza Community College District. On March 21, 2006, the City Council appointed Councilmember Judy Chirco as the City's representative to the Health Benefits Coalition. The coalition had its initial kick-off meeting in January 2006. It should be scheduling its next meeting after a critical mass of local governments, school districts, etc., have endorsed the coalition and, like San Jose, appointed representatives.
— The Bay Area Medical Review (BAMR) was organized by Cherie Rosenquist, City of Concord (and formerly of City of Milpitas), specifically to meet the needs the smaller government agencies that wished to terminate their relationship with CalPERS-Health. While San Jose is not part of CalPERS-Health, the City joined BAMR as a leading health care purchaser among government agencies in the South Bay and for the educational aspect of their meetings.

In summary, health insurance expenses are a significant portion of the City's operating budget ($47 million in 2006-07, or 5.5% of the $850 million 2006-07 Proposed Operating Budget), and they continue to increase at rates that exceed our revenue growth and other elements of our personnel costs. While the City has taken some steps to manage its share of premium expenses, substantive additional opportunities remain for the City to collaborate with our bargaining units and plan participants to address the underlying drivers of health insurance expenses and to generate long-term financial benefits.

/s/
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